



**ARIZONA DEPARTMENT OF HEALTH SERVICES  
BUREAU OF EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM  
CERTIFICATE OF NECESSITY - AMENDMENT**

**APPLICATION FORM**

**I. IDENTIFICATION**

Legal business or corporate name

Identifying Name (DBA)

Legal address

Mailing address if different

Telephone number

Facsimile number

E-mail Address

**II. MANAGEMENT**

**Provide the following for each applicant and individual responsible for managing the ground ambulance service:**

NAME	TITLE	ADDRESS	TELEPHONE NUMBER

**Provide the following for the business representative or designated manager:**

NAME	TITLE	ADDRESS	TELEPHONE NUMBER

**Provide the following for the individual to contact to access the ground ambulance service's records required in R9-25-910:**

NAME	TITLE	ADDRESS	TELEPHONE NUMBER

**Provide the following for the statutory agent for the ground ambulance service, if applicable:**

NAME	TITLE	ADDRESS	TELEPHONE NUMBER

**III. CLASSIFICATION**

<b>Type of Business</b>	Proprietary ___ Sole proprietorship ___ Partnership ___ Corporation for profit ___ Limited liability corporation ___ Other _____	Non-profit ___ Corporation ___ Other _____	Governmental ___ State ___ County ___ Municipal
<b>Level of Service:</b> (Check Most Approp)	___ Advanced Life Support	___ Advanced Life Support & Basic Life Support	___ Basic Life Support
<b>Type of Service</b> (Check all Applicable)	___ Immediate Response Transport	___ Interfacility Transport	___ Convalescent Transport
<b>Hours of Operation</b>	___ 24 hrs/7 days a week	___ Other (explain in detail on an attached sheet)	

#### IV. MEDICAL DIRECTION/COMMUNICATION

<b>Provide the following for each base hospital or centralized medical direction communications center:</b>		
NAME	ADDRESS	TELEPHONE NUMBER
<b>Provide the following for the ground ambulance service's dispatch center:</b>		
ADDRESS:	TELEPHONE NUMBER:	
<b>Provide the following for each suboperation station located within the proposed service area:</b>		
ADDRESS:	TELEPHONE NUMBER:	
<b>Provide a description of the communication equipment to be used in each:</b>		
<u>Ground ambulance vehicle:</u>		
<u>Suboperation station:</u>		

#### V. AMBULANCES

	Make of Vehicle	Year			Make of Vehicle	Year
1				1		
2				2		
3				3		
4				4		
5				5		

#### VI. AMBULANCE ATTENDANTS

Arizona Certified EMTs				First Responders operating under the provisions of ARS § 36-2202	Physicians licensed under Title 32, Chapter 13 or 17	Professional Nurses licensed under Title 32, Chapter 15	
BEMT	IEMT	PARA	Total			Prehospital Care	Interfacility Transport

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## AMENDMENTS TO A CERTIFICATE OF NECESSITY

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A certificate holder that wants to amend its certificate of necessity shall submit to the Department an application form for changes to:

1. The legal name of the ground ambulance service;
2. The legal address of the ground ambulance service;
3. The level of ground ambulance service;
4. The type of ground ambulance service;
5. The service area; or
6. The response times, response codes, or response-time tolerances.

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### INFORMATION REQUIRED AS PART OF THE APPLICATION PACKET

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In addition to the application form, an amending certificate holder shall submit:

1. For the addition of ALS ground ambulance service, the information required in R9-25-902(B)(1) and (B)(2).
  - a. A current written contract for ALS medical direction; and
  - b. Proof of professional liability insurance for ALS personnel required in R9-25-909(A)(1)(b).
2. For a change in the service area, the information required in R9-25-902(A)(3)(a);
  - a. A description of the proposed service area by any method specified in A.R.S. § 36-2233(E) and a map that illustrates the proposed service area;
3. For a change in response times, the information required in subsection R9-25-902(A)(2)(d);
  - a. The applicant's proposed response times, response codes, and response-time tolerances for each scene locality in the proposed service area, based on the following:
    - i. The population demographics within the proposed service area;
    - ii. The square miles within the proposed service area;
    - iii. The medical needs of the population within the proposed service area;
    - iv. The number of anticipated requests for each type and level of ground ambulance service in the proposed service area;
    - v. The available routes of travel within the proposed service area;
    - vi. The geographic features and environmental conditions within the proposed service area; and
    - vii. The available medical and emergency medical resources within the proposed service area;
4. A statement explaining the financial impact and impact on patient care anticipated by the proposed amendment;
5. Any other information or documents requested by the Director to clarify incomplete or ambiguous information or documents; and
6. Any documents, exhibits, or statements that the amending certificate holder wishes to submit to assist the Director in evaluating the proposed amendment.

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### APPLICATION FILING FEE

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A \$50 application filing fee for an amendment to a certificate of necessity, required as part of the application, is attached with the application packet.

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### ACKNOWLEDGMENT/SIGNATURE

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**I hereby certify, under penalty of perjury, that**

- \* I am duly authorized and qualified to act for or on behalf of the applicant(s) submitting this application.
- \* The applicant is requesting to operate ground ambulance vehicles and a ground ambulance service in this State;
- \* The applicant has received a copy of 9 A.A.C. 25 and A.R.S. Title 36, Chapter 21.1;
- \* The applicant will comply with the Department's statutes and rules in any matter relating to or affecting the ground ambulance service; and
- \* That the information and documentation contained in the application form, attached to the application form, submitted as part of the application packet, or submitted in any subsequent amendment or filing to this application has been complied from records I have verified, and I know that the facts recited herein are true and correct.

**X**  
\_\_\_\_\_  
Signature of the applicant or the applicant's designated representative

\_\_\_\_\_  
Date